STATE OF CALIFORNIA

DEPARTMENT OF MANAGED HEALTH CARE

PUBLIC MEETING ON HEALTH CARE PREMIUM RATES AND PRESCRIPTION DRUG COST TRANSPARENCY

DEPARTMENT OF MANAGED HEALTH CARE

980 9TH STREET

5TH FLOOR CONFERENCE ROOM

SACRAMENTO, CALIFORNIA

MONDAY, MARCH 11, 2026

1:00 P.M.

Reported by: Ramona Cota

ALL AMERICAN REPORTING, INC.
(916) 362-2345

APPEARANCES

PANEL MEMBERS/PRESENTERS

Department of Managed Health Care

Mary Watanabe, Director

Amanda Levy, Deputy Director, Health Policy and Stakeholder Relations

Sarah Ream, General Counsel

Michelle Yamanaka, Deputy Director, Office of Financial Review

Brian Stentz, Vice President & Principal, Lewis & Ellis, Consultant to DMHC

California Department of Insurance

Stesha Hodges, Chief, Health Equity and Access Office, Assistant Chief Counsel, Policy and Legislation Branch (participated virtually)

Joseph Williams, Senior Health Actuary (participated virtually)

Office of Health Care Affordability

Vishaal Pegany, Deputy Director (participated virtually)

APPEARANCES

MEMBERS OF THE PUBLIC COMMENTING

Georgia Brewer, Associate Director (participated virtually)
California OneCare Education Fund/HEAL California

Beth Capell
Health Access California

Victoria Heric (participated virtually)

Michelle Johnston, Director of Advocacy and Policy (participated virtually)
National Multiple Sclerosis Society

Michael Karsh (participated virtually)

Gilbert Lara
Biocom California

Michael Lighty, President
Healthy California Now

Bruce McLean
Butte County Health Care Coalition

Ben O'Brien, Director, State Policy Analysis
California Life Sciences

Lizzy Tapia, President (participated virtually)
Unite Here Local 2

Keith Umemoto
California Alliance for Retired Americans

C.T. Weber, Vice President
California Alliance for Retired Americans

Cindy Young, Vice President
California Alliance for Retired Americans

INDEX

		Page
1.	Welcome & Introductions	5
2.	Opening Remarks	7
3.	DMHC Summary of Health Care Premium Rates and Prescription Drug Costs	12
4.	California Department of Insurance Health Insurance Rates and Prescription Drug Costs	22
5.	Office of Health Care Affordability Perspective	31
6.	Public Comment	40
	Beth Capell	41
	Ben O'Brien	44
	Michael Lighty	45
	Cindy Young	48
	Bruce McLean	49
	Keith Umemoto	50
	Gilbert Lara	52
	C.T. Weber	53
	Michelle Johnston	54
	Lizzy Tapia	55
	Michael Karsh	57
	Georgia Brewer	57
	Victoria Heric	58
7.	Closing Remarks	59
Certificate of Reporter/Transcriber		60

PROCEEDINGS

1:02 p.m.

MS. LEVY: Good afternoon, everyone. Thank you for attending the Department of Managed Health Care public meeting on health care premium rates and prescription drug cost transparency. I am Amanda Levy, Deputy Director, Health Policy and Stakeholder Relations, and I will begin with a few announcements, some housekeeping items, then we will turn it over to our Director for Director's remarks.

Okay. This meeting is being conducted in a hybrid format, with the opportunity for public participation in-person or virtually through video conference and teleconference.

Please note the following items for those joining us in-person today, we will go over in-person first. The restrooms on this floor are locked. The bathroom badges are on the table at the back of the room; and please make sure if you use one to return it back to the table. There are two single-user all-gender bathrooms on the ground floor of the building near the mailroom. They are secured by a door code, which we can provide if needed.

There is a sanitation station located in the back of the room where you will find hand sanitizer right on the back along with our sign-in sheet.

Please remember to silence your cell phones.

Okay, all pretty standard so far.

For our attendees here in person, please do not join the Zoom meeting with your computer audio. I don't think anyone was planning on that, but it will create some feedback issues. For panelists and DMHC staff, we will not be joining -- we are joining -- you can see our pictures. We will not be joining

individually online.

Public comment will be taken after each agenda item. But there is also an opportunity, it will be taken again at the end of all the presentations when they have all concluded. So, if you wish, public comment can be given once you have heard the scope and the totality of all of the presentations.

For those who wish to make a comment, please remember to state your name and the organization you are representing. Public comment will be taken from individuals attending in person first. For those making public comment virtually, please use the Raised Hand feature. And if an attendee online has a question, please use the Raised Hand feature. All questions and comments from panelists will be taken in the order of which the raised hands appear.

Again, for those joining online or via telephone, please note the following. For the public attending online, as a reminder, you can join the Zoom meeting on your phone if you experience a connection issue. For attendees on the phone, if you would like to ask a question or make a comment, please dial *9. State the name and the organization you are representing.

For attendees participating online via telephone, you may use the Raised Hand feature and you will be unmuted to ask your question or offer comment.

Again to all online participants, to raise your hand to make a comment click on the icon labeled Participants on the bottom of your screen, then click the button labeled Raised Hand. Once you have asked your question or provided comment, please click Lower Hand.

Again, last reminder, this meeting is subject to the Bagley-Keene

Open Meeting Act. Operating in compliance with the Bagley-Keene Act can sometimes feel a little inefficient, but I think we have gotten it down, so I think it is going pretty well these days. But again, that is all meant to preserve the public's right to governmental transparency and accountability.

Due to the Bagley-Keene Open Meeting Act, the Zoom Chat has been disabled. If panelists encounter any issues, please send an email directly to do.admin.support@dmhc.ca.gov.

And one last reminder for those in the room. This meeting will not be recorded, but we will be using a transcription service. Our transcriber is here and wanted me to remind everyone to project when they speak because the ambient microphone doesn't always pick up softer voices very well. So, everyone, please use your loud outside voice so we can have a proper transcription, which we will be putting up on the website afterwards.

With that, that concludes our housekeeping items. I will move to our opening remarks from our Director Mary Watanabe.

DIRECTOR WATANABE: Good afternoon and welcome to our public meeting on prescription drug costs and premium rates. I see a number of folks in the room that were with us I think almost 10 years ago when we had our first meeting. I was reminiscing a little bit and reminded that I think since that time health care premiums have come close to almost doubling. I would say everyone in this room and joining virtually is probably well aware that the cost of our health care coverage is taking up more and more of our family budgets. It is competing with the rising housing costs and childcare. It feels like every week I go to the grocery store and something has gone up a dollar or 50 cents. And of course, I think we have all experienced the increases at the gas pump over the

last week in particular. For most of us, our paychecks are not keeping up with the pace of annual increases in our health care premiums or the cost of everything else that we need to budget for.

While the DMHC doesn't have the authority to deny rate increases, we do thoroughly review the rates that you are going to hear more about today. We ask the plans a lot of questions, for those in the room that represent a plan, but we really want to make sure they are reasonable and justified.

I believe transparency is important to the broader conversation about the cost of health care. I have had the pleasure of sitting in and participating and facilitating many of these meetings and I will just say, for those that are giving public comment today, the personal stories of what this means individually for you, the tradeoffs that you have had to make, have been really impactful and important to this discussion.

I am pleased that we will have representatives from the Office of Health Care Affordability with us again to talk about their efforts to address the rising cost of health care. And I appreciate our colleagues from the California Department of Insurance for joining us again for this joint meeting, so we have a comprehensive view of what is happening in the state-regulated commercial market in California.

And I just want to quickly take a moment to thank my team. Michelle Yamanaka, our actuaries, the team at Lewis & Ellis that do a fantastic job on all of the work that goes into the public report. I also want to acknowledge Amanda and our Director's Office admin team. There is a tremendous amount of work that goes into prepping and getting us ready for these public meetings. So, with that I will turn it back to Amanda.

MS. LEVY: Great, thank you. Next slide.

We won't take too much time to go over what the Department of Managed Health Care is, but we always think it is important to include at least a of couple slides in case anyone, if this is their first time attending this meeting, either in person or virtually. It is really important that you understand what we do, as the Director said, and just give a better sense of who we are.

So we do, as always, begin each of our public meetings with our mission statement; and this is a new mission statement since the last time you were here, if you were here two years ago. We embarked on a strategic plan and that resulted in, among other things, a new mission statement, which is:

> "The mission of the Department of Managed Health Care is to ensure health plan members have access to equitable, high-quality, timely, and affordable health care within a stable health care delivery system."

And this is an infographic from our Annual Report that is issued, will be issued later this year. This is from last year's report. And I think the two big points here that we want to emphasize is that now 30.2 million Californians' health care rights are protected by the DMHC, so we are over 30 million.

And then another, we won't go into the work of our Help Center, but we know how important it is, and certainly, I think, important and critical to the mission that we just recited. And we have now hit over 3 million consumers have been assisted by the folks at our Help Center. So just wanted to emphasize that. And certainly you will have all the information and if you have any questions, happy to answer any of those. Next slide.

So again, we just wanted to just take a couple of slides before we

get into our health care premium rates to talk about the Department of Managed Health Care, level set who we are and what we do.

We are the regulator of full service and specialized health care plans.

We have all HMO and some PPO/EPO products.

And within those 30 million individuals who are under our jurisdiction that's some large group and most of the small group and individual products.

We do have jurisdiction over most Medi-Cal Managed Care plans, and certainly we share that authority with the Department of Health Care Services.

In addition to the full service plans, our specialized plans include dental, vision, behavioral health, chiropractic and prescription drug plans.

And certainly, when we think of affordability and we think of rates, we do think about our friends, colleagues and family members who are using Medicare. But just to level set again, for Medicare Advantage our jurisdiction is only on the financial solvency of the plans, it is not on any of the benefits or premiums or anything else you can think of and any other issues that you might have with Medicare. But we certainly do have a role in ensuring that they are solvent to provide services. Next slide.

So, our key functions, again as we said, consumer protection. Again, these all go back to the mission statement that we just recited. And a lot of that is shown through the good work of our colleagues within our Help Center, who again, have assisted over 3 million health plan members.

Before there is an issue and you have to come to the Help Center

we start in the beginning. We license health plans initially and we ensure compliance with state laws.

We have a medical survey team that every three years reviews all functions of a health care service plan. We have Michelle Yamanaka, our Office of Financial Review, and her team conduct financial exams to ensure the financial stability of the plans.

We review, as our Director said, our proposed premium rate changes. We will talk a little bit about that process later.

And certainly, if a plan is acting outside accordance with state law we have our Office of Enforcement who can take enforcement action against that plan.

And now I will hand it over to my colleague Michelle Yamanaka and Brian Stentz from Lewis & Ellis. I don't know who is first.

MR. STENTZ: Good afternoon. I am a consulting actuary with Lewis & Ellis. We are contracted with the DMHC to perform various actuarial services, one of which includes performing actuarial rate reviews from health plans that are regulated by the DMHC. We performed this task alongside the DMHC's own internal actuaries.

Today, I will summarize the findings from the 2025 annual rate filings submitted from the individual, small group and large group filings.

Michelle will follow and present some of the key findings from the Prescription Drug Transparency Report for Measurement Year 2024.

The DMHC has issued two reports, the *Health Plan Aggregate Premium Rate Report* and the *Prescription Drug Transparency Report* that include more detailed information on these filings. These reports are available as

part of the meeting materials located on the DMHC's website.

Okay, market types. What does individual market, small group market and large group market types mean?

Large group coverage includes employer-sponsored coverage where an employer has over 100 employees.

Small group coverage includes employer-sponsored coverage where the employers have 1 to 100 employees.

And individual coverage is where the health plans offer coverage to the individual consumers directly, with the majority of these individuals purchasing their coverage through Covered California's Health Benefits Exchange. Next slide.

This slide provides a high-level summary of the 2025 annual rate filings.

The majority of the enrollees in the commercial market are covered by employer-sponsored plans in the large group market.

Approximately 7.49 million enrollees were in the large group market, compared to 2.57 million enrollees in the individual market and only 2.17 million enrollees in the small group market.

From 2021 to 2025, the average premiums have increased by over $150 per member per month.

The average premium per member per month was $684 in the individual market, $707 in the small group market and $689 in the large group market.

The weighted average rate increase was 7.6% in the individual market, 8% in the small group market and 6.5% for the large group market. For

comparison, Covered California had an average rate increase of 7.9% in 2025 and CalPERS had an average rate increase of 9% in 2025.

This chart shows the weighted average rate increases for health plans in the individual, small group and large group markets. As you can see from the chart, the average rate increases in 2025 were lower in all three markets compared to the 2024 average rate increases. However, based on the health plans' 2026 projected rate submissions, we do anticipate the rates slightly increasing in 2026 back closer to the 2024.

This chart shows the average monthly premium per member per month in the individual, small group and large group markets. The average premiums in the individual and large group markets are almost the same, while the small group market average premium was slightly higher in 2025. A majority of the enrollees and approximately 61% of all commercial enrollees are covered under the large group market. From 2021 to 2025 the average premium has increased in the individual market by $133 per member per month, for the small group market the average premiums have increased by $174 per member per month, and for the large group market the average premiums have increased by $155 per member per month.

Now I will summarize the individual market rates.

In 2020 California enacted Assembly Bill 2118 for the purpose of increasing the transparency of rates in the individual and small group markets. Health plans that offer commercial products in the individual and small group markets are required to report specified information to the DMHC by October 1 each year. This information includes premiums, cost sharing, benefits, enrollments, and trend factors. The DMHC is then required to annually present

this reported of information at various meetings as specified and also post the reports on the DMHC website no later than December 15 of each year.

Over the next few slides, we will summarize the individual market's aggregate rate information and weighted average rate changes on health plan premiums for Measurement Year 2025. We will also compare this information between on-exchange, off-exchange and grandfathered products.

Actually, can you go back one? Thank you. Sorry.

For Measurement Year 2025, 13 health plans submitted aggregate rate filings for the individual market. These 13 individual market plans covered approximately 2.6 million enrollees in 2025. This was an increase of approximately 124,000 members as compared to 2024. The weighted average rate increase was 7.6% and the average premium per enrollee was $684 per member per month.

As I mentioned, for the Measurement Year 2025 the DMHC received individual market aggregate rate filings from 13 health plans, which included five statewide health plans and eight regional health plans covering almost 2.6 million enrollees.

Twelve health plans offered individual products on-exchange, covering approximately 2.1 million enrollees with an average premium of $678 per member per month.

There were 12 health plans that offered individual products off-exchange and covered approximately 399,000 enrollees with an average premium of $707 per member per month.

Only two health plans, which were Anthem and Kaiser, offered grandfathered plans and covered approximately 31,000 enrollees with an

average premium of $815 per member per month.

In this section I will summarize the aggregate rate information in the weighted average rate changes on health plans in the small group market for Measurement Year 2025 as required by Assembly Bill 2118.

The DMHC received small group aggregate rate filings from 13 health plans for Measurement Year 2025 including 7 statewide plans and 6 regional plans.

In 2025 approximately 2.2 million enrollees had small group market coverage.

The weighted average rate increase was 8%, with an average premium per member per month of $707.

The small group off-exchange covered approximately 2 million enrollees, accounting for almost 90% of the total enrollment in the small group market. The weighted average increase for small group off-exchange products was 8.2% and had an average premium of $711 per member per month.

The small group grandfathered plans covered 129,000 enrollees, with an average rate increase of 6.8% and an average premium of $660 PMPM.

And in 2025 the on-exchange plans had an average rate increase of 6.9% for 83,000 enrollees with the average premium of $687 per member per month.

Next, I will go over the large group aggregate premium rates. Large group market health plans are required to annually file aggregate rate information and specified information regarding health plan spending and year-over-year increases for covered prescription drugs.

The DMHC is required to conduct a public meeting in every even-

numbered year to permit a public discussion regarding changes in rates, benefits and cost-sharing in the large group market.

Additionally, health plans are required to include information in their Notice of Premium Rate Change indicating whether the rate change is greater than the average rate increase for CalPERS and Covered California and the average rate increase in the large group market overall.

For Measurement Year 2025 the DMHC received aggregate rate filings from 22 health plans. There were approximately 7.49 million enrollees covered in the large group market in 2025. The large group -- the large group rate increased by 6.5% on average in 2025 and the average premium per enrollee was $689 per month.

As I mentioned earlier, health plans are also required to include information on their notices to employers that compare rate changes to those in Covered California and CalPERS. Covered California and CalPERS both negotiate rates with health plans similar to the way large employers negotiate, so this does at least provide a comparison for large group employers to consider.

This table provides the average rate increases from 2021 to 2025 for Covered California, CalPERS and the large group market. The rate increases had remained low in 2021 and 2022; however, they have started ticking up since 2023 consistent with general inflationary trends.

This table shows the average rate increase, the number of enrollees, and the average premium per member per month for all large group plans, Kaiser, and also all plans excluding Kaiser. Kaiser accounts for 67% of the large group market, so they have been separated here to show the average rate increases for all plans excluding Kaiser separately.

Kaiser reported an average rate increase of 6.1% with an average monthly premium of $677.

Excluding Kaiser, the remaining large group plans covered 2.5 million members and reported an average increase of 7.2% and an average premium of $711.

The average rate increase was 6.5% for all plans in the large group market and the average premium was $689.

AB 731 expanded the rate review practice that the state already had in place. Upon receiving a notice of a rate change, a large group contract holder that has coverage which is experience rated in whole or blended, can request the DMHC review its rate change if the contract holder makes his request within 60 days of receipt of the notice, and the plan being requested is a DMHC-regulated entity. To apply for a rate review of the change for a particular group, the group has to meet at least one of the following requirements.

The contract holder must have more than 2,000 enrollees, which includes both employees plus dependents, or the rate change is from a health plan that failed to provide required claims information requested by the large group employer.

There is a link on the DMHC website where large groups can submit their requests for rate reviews to the DMHC.

MS. YAMANAKA: Today I will briefly go over the prescription drug cost transparency report for Measurement Year 2024. Health plans are required to file rate information with the DMHC to report specific data related to prescription drugs. The reports are submitted annually and are due by October 1. Health plans must report information on the 25 most frequently prescribed

drugs, the 25 most costly drugs by total annual spending, and the 25 drugs with the highest year-over-year increase in total annual spending. The DMHC issues an annual report that summarizes how prescription drug costs impact health plan premiums.

A few items to note. The plan reporting is limited to prescription drug costs associated with the pharmacy benefit. The health plans do not include prescription drug costs for inpatient or hospital drugs or costs borne by the delegated medical groups, such as infusion drugs administered in a physician's office. These costs may be included in medical expenses.

The prescription drug costs for self-funded arrangements, Medi-Cal Managed Care, Medicare Advantage and health plans or insurers not regulated by the DMHC are not reported. By the 2024 reporting year there were 25 commercial health plans that submitted data, covering approximately 12.4 million Californians. Next slide, please.

Some key findings from our review.

Health plans paid approximately $14.9 billion for prescription drugs in 2024, an increase of almost $1.3 billion from 2023, and $6.2 billion from 2017.

Prescription drugs accounted for 15.4% of total health plan premiums in 2024, an increase from 15.2% in 2023.

On a per member per month basis, or PMPM, health plans' prescription drug costs increased by 10.8% in 2024, whereas medical expenses increased by 8.3% overall. Total health plan premiums increased by 9.3% from 2023 to 2024.

Manufacturer drug rebates totaled approximately $3.2 billion, up from $2.7 billion in 2023. This represents about 21.2% of the $14.9 billion spent

on premium prescription drugs in 2024.

Specialty drugs accounted for only 1.8% of all prescription drugs dispensed but accounted for 63% of the total annual spending on prescription drugs.

Generic drugs accounted for 88.8% of all prescribed drugs, but only 11.8% of the total annual spending on prescription drugs.

The total annual spending for generic, brand name and specialty drugs all increased in 2024. In particular, diabetes or weight loss drugs, immunological drugs and antiviral drugs showed significant increases among the top 25 most costly brand names and specialty drugs. Several of these drugs, such as Ozempic, Jardiance and Paxlovid, had the highest year-over-year increase in total annual spending. Consistent with these findings, other industry reports affirm that anti-obesity or weight loss GLP-1 and immunological drugs rank among the most rapidly expanding drugs. These were classified as either brand name or specialty.

Looking at this next slide, this chart shows the total health plan premiums, medical expenses, prescription drug expenses and profit on a per member per month basis from years 2017 to 2024. The 2023 data may differ from last year's report for Measurement Year 2023 as the 2023 data was updated to reflect restatements submitted by several health plans. All categories except profit increased consistently from 2017 to 2024. On average, members paid nearly $648 per month for health plan premiums in 2024, compared to $592 in 2023 and $455 in 2017. This means the average premium has gone up approximately 43% since 2017. Prescription drug expense increased by 70.4% over the last eight years, while medical expenses increased by 42%.

The next two slides will show the cumulative increase for both medical expenses and prescription drug costs. As I mentioned, the 2023 data may differ from last year's report for Measurement Year 2023, as the 2023 data was updated to reflect restatements submitted by several health plans. Next slide, please.

This chart shows the year-over-year increase in medical expenses on a per member per month basis, as shown in the blue bars. The green line represents the cumulative increase over the past eight years. Medical expenses increased by 42% over these last eight years. Next slide, please.

This chart shows the year-over-year increase in prescription drug costs on a per member per month basis, as shown in the blue bars. The cumulative increase over the last eight years is shown on the green line. Prescription drug costs have increased by 70.4% over the last eight years. On average, prescription drug costs increased about 8% each year. However, in the last three years, the increase is higher than the eight year average. This significant increase from 2023 to 2024 is primarily due to the increase in spending on brand name and specialty drugs. Next slide, please.

Last year, Governor Newsom signed two bills, Assembly Bill 116 and Senate Bill 41, to address the need for greater transparency regarding the cost of prescription drugs and the role of Pharmacy Benefit Managers or PBMs.

Senate Bill 41 reforms the allowable business practices for Pharmacy Benefit Managers. It also reforms the revenue generating abilities of PBMs, including prohibiting the practice of spread pricing, requiring manufacturer rebates to be passed through to the health plans, and allowing for only administrative fee charges to be assessed to health plans.

It also reforms pharmacy network practices, including prohibiting discrimination against nonaffiliated pharmacies and requiring PBMs to address any pharmacy willing to adopt standard terms to their networks.

The DMHC will begin licensing PBMs starting January 1, 2027.

The DMHC will continue to collect and annually report the data contained in this report to show historical trends and the impact of the new PBM requirements on prescription drug costs and health care premiums. Next slide.

The links to the reports that we discussed today are located on the slide. Thank you.

MS. LEVY: Thank you, Michelle; thank you, Brian.

We are next going to hear from our colleagues from the California Department of Insurance on their health insurance rates and prescription drug costs. And I believe we will be starting with Joseph; is that correct?

MS. HODGES: I will start. Stesha Hodges, I will start.

MS. LEVY: We will start with Stesha, okay. Take it away.

MS. HODGES: Thank you. Good afternoon. I am Stesha Hodges. I am an Assistant Chief Counsel and Chief of the Health Equity and Access Office at the California Department of Insurance.

Before I start, I wanted to thank Director Watanabe, Amanda, Michelle, and all of DMHC's wonderful staff for kindly hosting this public meeting, for putting the meeting together and for inviting us to participate, we really appreciate it.

Now I want to welcome you all to the California Department of Insurance portion of this public meeting, which pertains to health insurance rates and prescription drug costs. Next slide, please.

However, before we start I want to give you a brief overview about the California Department of Insurance or CDI. CDI was created in 1868 as part of a national system of state-based insurance regulation.

CDI is led by Insurance Commissioner Ricardo Lara, who is the eighth Insurance Commissioner since voters created this elected position in 1988.

California is the largest insurance market in the United States and the third largest insurance market in the world, with annual direct premiums of over $477 billion.

CDI is tasked with regulating more than 1400 insurance companies across all lines of insurance, this includes life insurance, property-casualty, long-term care and health insurance.

In the health insurance space, CDI regulates health insurance products offered by health insurers. This includes review and prior approval of health insurance policies, review of health insurer networks and prescription drug formularies, as well as review of health insurance rates to ensure compliance with state law. Next slide, please.

CDI has a consumer protection mission and focus, including overseeing insurer solvency, licensing agents and brokers, conducting market conduct reviews, investigating and prosecuting insurance fraud, and resolving consumer complaints.

Across all insurance regulated by CDI, in 2024 our Consumer Services Division received more than 206,000 consumer assistance calls, investigated and resolved more than 62,000 consumer complaints, and as a result recovered more than $132 million for consumers. This work included

providing in-person assistance at local assistance centers and disaster recovery centers in responding to in-person requests for assistance after a disaster.

If you need any assistance with your insurance, go to our public website at www.insurance.ca.gov and press on the File a Complaint tab; or else you can call our hotline at 1-800-927-4357. That is 1- 800-927-HELP. Next slide, please.

Now we will transition to the part of the presentation you are all here for, the health insurance rate presentation. I would like to introduce one of our senior health actuaries, Joseph Williams, who will present information regarding health insurance rates, starting with large group. Joe, take it away.

MR. WILLIAMS: Thank you, Stesha, and good afternoon, everybody. As Stesha said, I will start with presenting information on data received from the SB 546 large group rate data filings. Next slide, please.

The large group aggregate rate data is available on the Department's website at www.insurance.ca.gov. Just type “Large Group Rate” into the search box in the upper right of the home screen and that will take you to a link to large group rate submissions as well as prescription drug cost data submitted by each insurer this year. Next slide, please.

In 2025 CDI received large group aggregate rate data from 6 health insurers. This slide here we have their market share, the total covered lives of 415,000. Next slide, please.

This slide shows a breakout of members in Experience Rated versus Community Rated versus Blended groups. We see 44% in Experience Rated. This means that the company develops the employer’s rate based on the group's own experience.

4% are in Community Rated. That is that the rate is based on the broader experience of multiple groups combined to create a rate manual that they will use.

And then 52%, the remaining, are in Blended groups. This means that the employer's own experience is considered partially credible, so it is blended with the community experience to develop the group's rate. Next slide, please.

The Department now has 10 years of SB 546 data. Here we show how the mix between PPO, EPO and HDHP products have changed over the years. The data indicates that the product mix has been relatively stable. Maybe we see a slight shift from PPO to HDHP over the years. Next slide, please.

This slide shows the distribution of members by their actuarial value. Actuarial value is a measure of how rich a plan is. The value estimates the percent of claim costs that a plan is expected to cover based on the cost sharing design of the plan. We have here 22% of members are in plans that cover, that are expected to cover 90% of claim costs. And to combine the first two bars there, 86% of members are in plans that are expected to cover at least 80% of claim costs. We will see as we get into the other markets different distributions on the actuarial value, but in general what we see here is that large group market members tend to be in larger and richer benefits -- plans with richer benefits compared to the individual and small group. Next slide, please.

This is the average PMPM, average premium PMPM on the top portion, and we can see the increase year-over-year since we have been getting this data. In 2024 the average premium PMPM increased 9%. This is higher than previous years. But we can also see in the bottom the average PMPM by

claims in 2024, that went up by 10.8%. Next slide, please.

Health insurers are required to include information in their notices of premium rate change indicating whether the rate change is greater than the average increase for Covered California and CalPERS. The 2026 rate increases are 8.4% for CalPERS and 10.3% for Covered California. Next slide, please.

This slide shows the weighted average annual 2025 over 2024 rate increases for the five large group health insurers. The blue bar shows unadjusted increases, while the red bar shows the average increases adjusted for changes in benefits and demographics. You can think of the blue bars as the change in rate table, while the red bar reflects that but also any benefit changes that occurred. We see a range here from 7.1% with KPIC, up to 15.3% with Blue Shield. Next slide, please.

This slide shows rate changes by product type. For 2024 reporting year we see that between the PPO, EPO and HDHP, all received increases around 9 to 10%; whereas 2025 increases were a bit higher, particularly with the EPO plans receiving 17.4% on average. Next slide.

This is the overall medical trend. On the top of the slide we have the experienced trend from 2024 to through 2025 and then the bottom portion of the graph shows the projected trend going into 2026. Most companies are projecting similar trends in 2026 as to what they experienced in 2025. Next slide.

Here we have the projected trend broken out by service category, with Hospital Inpatient, Hospital Outpatient including Emergency Care, Professional Services and Prescription Drug. You can see the variation in trend projections by service category, with a bit of variance within each company here. Next slide.

This slide shows the average estimated post-tax margin as a percent of premium on the top figure. This is average across all companies for each year, 2020 through 2024. We can see three of the last five years experienced post-tax profit margin of less than 1%. The bottom portion of this graph shows each carrier's average over those years. Next slide, please.

This slide shows the average administrative expenses as a percent of premium. The top is the aggregate information for all insurers for each year. Again, the bottom figure shows the average -- each insurer's average administrative expense as a percent of premium. We see a range here from 4% up to 13.8%. Next slide.

Okay, this year the scope of our presentation has expanded to include data from carriers offering student health coverage. So now we are going to take a look at the SB 546 submissions regarding student data. Next slide.

The student data, the student rate data is available on the department's website in the same place as the large group rate data. So, just go to www.insurance.ca.gov and type "Large Group Rate" into the search bar for the student rate data. Next slide.

In 2025 CDI received student rate data from five health insurers. In this slide we show their market, their market share. Next slide.

With two years of collecting data we have -- we can see how their product mix has changed from 2024 to 2025 between the PPO, EPO and POS. We see a slight shift probably going towards the PPO here. Next slide.

This slide, again, shows the distribution by actuarial value. Here we see student plans are pretty rich, 99% of members are in plans that are

expected to cover over 80% of costs. Student plans tend to be fairly rich, with most of them offering Gold or Platinum level plans. Next slide.

Here we have the experience trend for 2025 over 2024 for four of the carriers. And then the projected trends for going into 2026. Next slide.

And again, those projected trends broken out by service, by the four service categories. Next slide.

Now we are going to move into our analysis of the individual market. We will look at data submitted from Assembly Bill 2118 on the individual market first and then we will do small group. Next slide.

The individual and small group aggregate data is available on the department's website at www.insurance.ca.gov. Type “individual and small group aggregate rate” into the search bar of the upper right of the home screen and that will take you to a link to the individual and small group rate submissions. Next slide.

In 2025 CDI received individual aggregate rate data from three insurers. And you can see one of the three has a very small market share so the remaining slides on the individual market will focus on the Anthem and Blue Shield data, which are both grandfathered. I think all three are grandfathered plans. Next slide.

Here we have the experienced trend for each and the projected trend. You can see they are projecting lower trends for 2026 than they had experienced in 2025. Next slide.

Here is the projected trend broken out by service categories. We see a negative for Blue Shield in the Hospital Inpatient. I think in their experience they experienced some negative utilization on this grandfathered block, and it

looks like they are projecting that to continue a bit in 2026. Next slide.

Now we will look at the small group data from the AB 2118 submissions. Next slide.

Small group data is found in the same place I talked about for the individual. Go to www.insurance.ca.gov and type in “individual and small group aggregate rate” into the search bar. Next slide.

In 2025 CDI received small group rate data from five insurers. Here is their market share. Cigna here actually has withdrawn from the market so we won't see their data in the, in the trend slides, in the trend slides going forward. Next slide.

Here is the distribution by actuarial value in the small group market. You can see it is very different from what we saw in the, in the large group and student markets. Here we have it looks like around 35% of insureds are in plans that cover over 80% or expect to cover over 80% of claim costs. I think that was, that was 86% for the large group and 99% for the student. And you can see the large amount in the Bronze. Almost half of insureds are in Bronze plans, so that is an actuarial value that is expected to cover 50-60% of claim costs. Next slide.

Here is the -- the top graph shows the actual medical trend by company for 2025 over 2024. And the bottom graph shows the projected trends for 2026 compared to 2025. It looks like companies are projecting around the same that they experienced in 2025. Next slide.

And here is the breakout of the projected trend by service category. Again, we see variation between carriers in each of the categories. The one thing we do see is each of the carriers are projecting their highest trends, or higher trends for the prescription drug compared to the other four categories.

Next slide.

I am going to hand it off to Stesha to talk about prescription drugs. Thank you very much.

MS. HODGES: Thank you, Joe. Okay. Insurers are required pursuant to Senate Bill 17, which was enacted in 2017, to report information regarding outpatient, generic, brand name and specialty drugs in three categories, the 25 most frequently prescribed drugs, the 25 most costly drugs by annual plan spending including cost sharing, and the 25 drugs with the highest year-over-year increase. This is a summary of CDI's findings based upon an analysis of the prescription drug cost information provided by health insurers in the individual, small group, large group, and student health insurance markets. Next slide, please.

So, eight health insurers submitted the prescription drug data required by SB 17 to CDI. From 2022 to 2024 -- sorry. From 2023 to 2024 there was an average increase of 11.7% in cost per prescription drug. However, the amount of cost increase varies drastically depending upon the drug category. For instance, the change for generics was an increase of 1.3%, while the change of cost for specialty drugs increased by 7.4%. The change for brand name drugs is an increase of 19.5%. And we think this was due to lower utilization of COVID-19 vaccines in 2024 and an increase in the specialty drug threshold from $830 in 2023 to $950 in 2024, both of which impact the comparison of 2023 drug costs to the 2024 drug costs. These numbers do not account for rebates as separate rebate information from generic, brand name, and specialty drugs is not available. Next slide, please.

So, this slide shows cost and utilization for 2024. So, the circle on

the left shows that 85% of prescriptions are for generics, but only 4% of prescriptions are for specialty drugs. This is similar to what we saw in 2022, plus or minus a few percentage of points.

In contrast, the circle on the right shows that as a percentage of costs, specialty drugs account for 71% of prescription drug costs, and this is up from 65% of costs in 2022. Generics only account for 12% of costs, which is down by 1% from 2022.

And then finally, brand name drugs account for 17% of costs, which is down from, sorry, 22% in 2022.

These figures demonstrate that generic drugs are very cost efficient. Next slide, please.

So, this slide shows the top three most prescribed drugs in each category, as well as their ranking and annual spending by each respective category.

For specialty drugs the top three most prescribed drugs are all blood glucose regulators. For instance, Mounjaro was the most prescribed specialty drug, but it was number five in annual spending.

For brand drugs the top three most prescribed drugs include two vaccines and another blood glucose regulator, Ozempic. Interestingly, Ozempic was number one in annual spending for brand drugs, but it also ended up being number 11 spending for specialty depending upon how insurers had them on their formulary. This information is displayed to show a preview of the more detailed information available to you in the Department's report. Next slide, please.

You can find our report on the Department's website. That's

www.insurance.ca.gov and then search for “Special Health Topics and Resources” and you will find a link to the report. Next slide, please.

Thank you. This concludes the CDI portion of this meeting. Thank you for your interest in our presentation. And once again thank you to DMHC for hosting.

MS. LEVY: Great, wonderful. Thank you, Stesha, and thank you, Joe, for participating and giving a lot of very useful, valuable information. So again, we will take -- we will ask for public comment at the end, so if you both can stick around we would appreciate it in case there are any questions directed to you specifically.

And with that, we are going to move now to the Office of Health Care Affordability perspective, and we have Deputy Director Vishaal Pegany with us from OHCA. Vishaal will be participating virtually, so we will give him a minute to get up on the screen. There he is. Hi, Vishaal, thanks for being here. We have your slides up and running, so we will turn it over to you.

MR. PEGANY: Great, thank you. Are you hearing me clearly?

MS. LEVY: Yes, that sounds good.

MR. PEGANY: Great. I am happy to be back here again for the large group rates meeting and providing an OHCA update.

First, I wanted to start off on the next slide, which is an overview slide. If we could go one more.

I will cover a little bit about the department that we are housed within, including our mission and program areas. So, this is an updated mission statement for HCAI, which is to expand access to quality, equitable, affordable health care for all Californians by supporting high value delivery systems,

resilient health facilities and workforces, and actionable health information and strategies. Next slide.

So, HCAI has a pretty broad portfolio, as many of you know. We are the hospital building and seismic compliance department.

We also provide loan insurance for health facilities for their capital improvements.

We do a lot around workforce in terms of scholarship loan repayment programs and ensuring access to a diverse workforce in the state.

So, some of our key assets here at HCAI are our data programs. We house the health care payments data program, which is a claims database for millions of Californians, which allows transparency on costs and outcomes.

And then affordability is the newest pillar to HCAI's portfolio, which I will be going over with the addition of OHCA. We also enforce hospital fair billing protections. And then HCAI also administers the CalRx program, which has launched an affordable insulin this past January. So, I will take us to our next slide.

So, OHCA was established in 2022 in response to the crisis in terms of health care affordability. It is governed by a eight-member Health Care Affordability Board. We have various advisory committees and technical work groups. But essentially kind of the three key components are to slow spending growth, promote high value, and assess market consolidation. So, the way these three components work together is that we collect, analyze, and publicly report data on total health care spending, and then we enforce the spending targets, which I will cover shortly.

You know, at the same time that we are slowing spending growth

we want to have a focus on maintaining or improving quality and equity.

We will measure the shift towards alternative payment or value-based payments that are linked to quality.

We also measure the extent to which health plans are investing in primary care and behavioral health.

As well as monitor the stability of the health care workforce.

And then lastly, through our cost to market impact review program, we review transactions, you know, transactions that are mergers and acquisitions of health care entities for their impact on market competition, affordability for consumers. And, you know, depending on the concerns we identify in our reviews we could escalate any findings to relevant state agencies including the two regulators, CDI and DMHC, as well as the Attorney General. Next slide.

So, I will provide a bit of context for some of the trends we are seeing and how that informed the establishment of the statewide spending target. So, next slide.

So, this graph shows the growth in health care spending as a share of median income, with the US shown in red and California in blue.

So, California households spent about 7.9 or 8% on health care in 1991 and this has grown over time to 13.3% in 2020. And then as households spend more on health care, this crowds out other necessities such as housing and education. Next slide.

So, this looks at per capita health care spending in California, which has grown from around $2,700 to $10,300 per capita, or per person, over a 30-year period. If we take an average of the percentage growth per year, that will equate to 4.8% or roughly 5% per year. And then I will take us to our next slide.

So, some of the human toll in terms of these costs is that recent survey data from the California Health Care Foundation reports that 6 in 10 Californians report postponing or skipping care due to cost; and 4 in 10 report saying that skipping care made their condition worse. Next slide.

And then I will take us to the subsequent slide, which is our spending targets. So, we have a Health Care Affordability Board, as I mentioned. They approve the statewide spending target, which is based on median household income. So, we took a look at 20 years of historical data and on average family income grew about 3% per year. So, the signal that the Board wanted to send to the market is that health care spending should not grow faster than the income of California's families. So, the target initially starts at three and a half. It phases down to 3% by 2029.

So, the first year that the target, which is target year 2025, that is going to measure the rate of change from 2024 to 2025. That year is non-enforceable; it is simply a reporting year only.

And then 2026 is the first enforceable year and we will begin collecting data on that in fall of 2027 and that will measure the change between 2025 and 2026. Next slide.

So, for the past two years OHCA has heard public testimony about high hospital costs from consumers, from union representatives, from union members, from hospitality workers and teachers. So, we began taking a look at a variation in hospital prices across the state. We looked at CMS data, which showed that nearly 40% of health care spending in California occurs in hospitals, making this a potentially high impact area to improve affordability. The literature also shows hospital prices vary widely across the state, with prices varying five

times. And it is not attributed to higher quality or better outcomes but is instead correlated with market concentration.

So, the Board took an early vote in January of 2025 to define all hospitals as a sector. We have authority in the OHCA statute to establish health care sectors. This enables the Board to adjust targets for high-cost hospitals.

So, the board voted unanimously in April 2025 to adjust -- to set targets for all hospitals, including adjusting for seven high-cost hospitals.

So, the slide I showed previously about the statewide target, most hospitals are subject to those targets. For the seven high-cost hospitals listed here, the Board adjusted the target by half. And this was based on data that we presented that when we looked at commercial unit prices for inpatient stays, these seven hospitals collectively were double the statewide average. And when we looked at how their commercial pricing is relative to Medicare pricing, we found a similar trend of about over one and a half times or 150% higher commercial prices. So, that was kind of the basis of adjusting the target by half.

And then each year the office will provide an updated list of hospitals which meet certain criteria, and then we also can propose additional criteria or factors for identifying the high-cost hospitals. Next slide.

So, including here a flow chart of how enforcement will work. I won't go over every little detail, but this is more of a leave-behind. But there is essentially a process where entities submit data, we will take some time to analyze the data. We will notify them if they exceeded the target. We will provide technical assistance. And for certain entities we may move them along to a performance improvement plan; and that is where the health care entity proposes strategies, cost reducing strategies, and then also must comply with

certain guardrails for access, quality, equity and workforce stability.

OHCA will approve and monitor the implementation of the PIP and progress. These PIPs could be up to three years depending on what is proposed and approved. If the entity complies with the PIP and they meet the target enforcement ends. If the entity fails to implement the PIP, then they may be subject to financial penalties for noncompliance. Next slide.

So, we included this slide to provide some differentiation between DMHC's rate setting process -- or rate review process, excuse me -- and OHCA's spending target enforcement process.

So, DMHC as well as CDI assesses premiums as a projection of health care spending based on assumptions about growth. When plans project correctly they can cover all their expenses and make a margin. If they underestimate costs, they could lose money.

And then when I take -- when we shift over to the blue columns in terms of the OHCA spending targets, OHCA really has a focus on the actual total health care expenditures that were incurred, and OHCA will report annual spending that occurred two years prior. So, this is because there is quite a bit of lag between data collection and reporting. So, plans will report to us on their 2026 performance in fall of 2027. That will measure the change between 2025 and 2026. And then because we get the data in fall of 2027 we are going to take some time to analyze and validate the data, and then enforcement would begin sometime in 2028.

During this process there is a feedback loop between OHCA, DMHC and CDI where we will consult with -- before we take an enforcement action against a plan OHCA will consult with DMHC. At the same time, DMHC is

considering the impact of targets on health care costs during their rate review process. Both OHCA, DMHC and CDI will glean information about what they are hearing from payers, and this will be informative to all three departments in terms of informing what are the next steps for enforcement. Next slide.

So, I will provide a brief overview of OHCA's data collection, reporting and cost driver analyses. If we could go to the next slide.

So, this includes some top line findings from our baseline report, which was reporting on spending that occurred between 2022 and 2023.

Overall, health care spending in California on an aggregate basis was $408 billion.

When we look at it on a per person per year or a per capita trend, it was an increase of about 6.4% for commercial spending, 5.4% for Medicare. This would include both Medicare Advantage and fee-for-service. And then for Medi-Cal the same thing in terms of fee-for-service, Medi-Cal and Managed Care, and the growth rate was 2.9% for that market.

When we combine all these markets as well as other state and federal health care spending, the overall per capita increase was 8.2%. Next slide.

So, I covered a lot of these trends on the prior slide. This is just kind of more of a visual of the growth rates. Next slide.

And wanted to share some cost driver analyses that we have been doing. So, the OHCA data is very aggregated. It will let you know kind of top line trends in terms of percent changes as well as percent changes in certain categories like inpatient or retail drugs. But we won't necessarily know what's driving -- the drivers of spending, or why we are seeing certain things. Is it due to

utilization? Is it due to due to prices?

So, the benefit of OHCA being housed within HCAI is that we have access to the health care payments database. This past January we published our first cost driver analysis which looked at claims data. We looked specifically at the commercial market, examining average age, service utilization, and prevalence of chronic conditions among commercial enrollees as explanatory factors for the spending growth that we observed. Next slide.

So, this shows some of the trends we saw, which is that on average commercial plans saw no meaningful change in average age.

We did see a decrease in the share of members who utilized health care services.

Some plans did report decreases in chronic condition prevalence, while the other 9 showed an increase in the share of members with chronic conditions.

And then given that the utilization of care decreased for all commercial payers, the growth in TME is likely due to higher prices or intensity of utilization, which we will explore in the future. Next slide.

And then this report is just, we will be providing updated data on 2023 and 2024, you know, with the collection of new data. And in this report we will also include physician organization level reporting. So far today we have only reported on plans, and we will be adding a new level of provider reporting in this forthcoming report. Next slide. If we could go one more slide.

So, OHCA works to promote -- we are not just focused on costs alone but also improving the system and we do this through five focus areas, which is primary care investment, where we are measuring how much health

plans are increasing investment in primary care. So, we know we spent about six to seven cents out of every dollar. OHCA has set a benchmark of 15% over a 10 year period and we will be measuring progress towards that benchmark.

For behavioral health we will set a similar benchmark. We will provide a recommendation to the Board this summer.

We also measure Alternative Payment Model adoption.

And at the same time that we will be reporting on spending performance we will also report on quality and equity performance to make sure that we have -- we are actively monitoring that as cost reducing strategies are implemented, that it doesn't compromise the quality and equity of care.

And then we also will be reporting on various measures on workforce stability in the future as well. If we could go to the next slide.

So, I won't go over this in detail as I just covered it, but these are some of the milestones that we have reached for health system performance.

With the last one, the last bullet here is that we are finalizing an approach on how to measure behavioral health spending. There is a lot less done in this area, and we are breaking some new ground in terms of establishing a definition and collecting data on behavioral health spending by plans. Next slide.

So, this slide is a preview of an upcoming report. So, with the collection of new data on 2023 and 2024 we will be reporting on how many members are in an APM arrangement, including the ones that are higher on the continuum of value-based payments, which are HCP-LAN Categories 3 and 4.

We will also present data on primary care spending by plans, including the percent of spending as a, as a share of total health care spending,

as well as by different dimensions like product type, line of business, et cetera. And I will take us to our next section, if we could go two more slides.

So, I will cover our market consolidation activities. So, we get advance notice of a pending merger or acquisition involving health care entities, which could be a health plan, hospital, physician org, or other entities defined under the OHCA statute.

We will review the notice to see if it rises to a level of concern.

If it does then we would do a full Cost and Market Impact Review for impacts on costs, access, quality, labor or market concentration.

To date, we have received over 40 -- we have reviewed 40 transactions, and then we currently have two Cost and Market Impact Reviews pending.

And that wraps up my overview and update on OHCA. Happy to turn it back over to DMHC.

MS. LEVY: Great. Thank you, Vishaal, so much for being here and for providing all that information. I believe there is an appendix with additional information for all those who are in the room or who have accessed our presentation online.

So, with that, if we can move forward to our public comment slide. Great. Well, thank you all so much for sticking with us. There was a lot of information. We recognize that it is very dense; but we also recognize how valuable this meeting can be with all of this information presented by the two regulators and our colleagues from OHCA in all one place.

So, with that, we are going to move to our public comment section. We will ask those who wish to give public comment to line up at the microphone

and podium in the middle of the room.

And if I could ask those online who wish to give public comment to use the Raised Hand feature. We will call on you on the order in which you are called, but I am asking if you can do so now so we can better estimate how many people will be presenting or will be giving public comment. And as our agenda said, we may need to impose time limits. But right now we have about five in the room and just a couple online, so we will start. Please be as thorough as you need to, to get your point across. We will not impose strict time limits at the moment, but we have about an hour and a half for all public comments, so I think we should be able to get through everything. So, with that, if you can, the microphone should be on, and if you can state your name and organization for the record, please.

MS. CAPELL: Beth Capell with Health Access California. I want to start by thanking the regulators and the Office of Health Care Affordability for this wealth of information. It may seem odd now, but when these reports began, whether it is the report on prescription drug costs or the report on rates, all of this was secret information. Literally, there was no way to know what the rate increases were. It was considered proprietary, confidential information. So, it has been a revolutionary change in the last 10 or 15 years to be able to have this information. The same is true of the prescription drug information that we now regard as routine. It was -- that was a hard-fought battle to get to even this level of transparency. And we would certainly support more but we are pleased with what we have.

I want to turn now to the discussion about the Office of Health Care Affordability and the two regulators.

Six years ago, Governor Newsom proposed the creation of the Office of Health Care Affordability to make health care more affordable for consumers and other purchasers.

You have heard a few of the facts. I will add that today 7 in 10 Californians say they have difficulty affording health care, and Californians are more afraid of a surprise medical bill than unaffordable housing costs. Which, given how unaffordable housing is in California, is a testament to the need for action.

For the 80% or so of California tax households that live on less than 150 or $160,000 a year, these are daily realities of being unable to afford care. The targets that you heard about from the Office of Health Care Affordability were set with the acknowledged -- based on the increase in median family incomes because of the concern of the Board, the Health Care Affordability Board, about the lack of affordability.

The most common question we get about OHCA is, how will it lower health care costs? And the second most common question is, when?

So, we are here today to begin to provide part of that answer. The work of OHCA provides the first part. There will be lots of parts, but the next part is that we call on the Department of Managed Health Care and the Department of Insurance to find unjustified any rate that does not -- proposed by a plan or insurer, that does not demonstrate the impact of the OHCA targets.

We also call on both departments, consider whether a rate is unreasonable if medical trend, particularly for hospital inpatient and outpatient and professional services, which are also subject to the OHCA targets, exceed the OHCA targets.

Beyond that we have taken a look at some of the small group filings in the last year. We appreciate that DMHC has sometimes asked about the OHCA targets, but we ask for stronger action and greater clarity in what the request is, and we will be providing additional comments in writing. We ask that if medical trend, particularly for hospitals or large physician organizations, exceeds the OHCA targets, that the plan or insurer be required to provide detailed information that the department may -- the department -- the appropriate department may transmit to the Office of Health Care Affordability in order to allow the Office of Health Care Affordability to do its job of enforcing the targets for hospitals and large physician organizations. And by detailed information we mean things like NPIs and the names on the many lists that OHCA is compiling and the HBD is compiling of large physician organizations and hospitals and health facilities. And by larger physician organizations we mean the definition in the OHCA law, not just risk-bearing organizations regulated by the Department of Managed Health Care.

We recognize that greater affordability rests on enforcement of the law and that this will be an iterative process, and this is simply another step in that discussion. But it begins with the Department of Managed Health Care and the Department of Insurance and the Office of Health Care Affordability using the authority they have already been granted by existing law to require first that plans and insurers demonstrate the impact of the OHCA targets in proposing rates, and for the Office of Health Care Affordability to exercise the enforcement capacity that you just heard discussed.

We recognize there are lots of technical issues to work through, but technical issues can be worked through. That should not be an impediment to

moving forward to answering the question we hear every day when we talk about OHCA, which is, how will consumers benefit and when will it happen? Thank you.

MS. LEVY: Thank you. Next, again, if you can please state your name and organization for the record. And for those standing, if you want to sit down in the front row, you can. We just needed to get an estimate of how many people were going to be speaking. If not, if you are comfortable, please continue to stand. We will take you, we will take you in the next --

MR. O'BRIEN: Sorry, I am going to adjust the microphone a little bit. But good afternoon and thank you to the DMHC staff for this meeting and for this opportunity to comment. My name is Ben O'Brien, and I serve as the Director of State Policy Analysis with California Life Sciences. So today I am speaking on behalf of our more than 1300 member organizations including pharmaceutical, biotechnology, medical technology and academic research institutions committed to advancing innovation and improving health outcomes across California.

Again, we appreciate the Department's continued focus on health care affordability and the role prescription drugs play in premium spending. We share the goal of ensuring that patients can access the therapies they need without facing financial barriers. As the Department's most recent annual prescription drug pricing report found, medical services accounted for roughly 76.5% of total health plan premiums. By comparison, prescription drugs represented 15.4% of premiums; and after accounting for manufacturer rebates the net share drops to approximately 12%. In other words, nearly three-quarters of every premium dollar is going towards medical services, or roughly one-eighth reflects prescription drug spending.

When evaluating drug spending, we recognize that much of the growth is concentrated in specialty medicines. While these therapies account for a relatively small share of total prescriptions, they represent a large portion of overall spending. This is because they are designed to treat serious, complex and previously untreatable conditions. The spending reflects the value these medicines can deliver. Specialty therapies often help prevent costly hospitalizations, surgeries and long-term complications, while significantly improving patients' quality of life and health outcomes. In many cases, these treatments will reduce downstream medical costs and enable outcomes that would not have previously been possible with older therapies.

None of this is to say that the health care affordability challenges we face as a state and a nation are not real. They certainly are. But the data shows that focusing narrowly on the impact of drug prices risks understating other key drivers including utilization patterns, administrative costs, spread pricing and other practices that drive profit margins within other sectors of the health care spectrum including insurance and PBMs.

In closing, we appreciate the Department's work on this and stand ready to serve as a resource moving forward. Thanks again for this opportunity to comment.

MS. LEVY: Thank you. Thank you. Please state --

MR. LIGHTY: Hi. My name is Michael Lighty. I am President of Healthy California Now, and Alma has graciously agreed to help display a graphic.

I want to first associate ourselves in support of the comments from Beth Capell. I think that that really captures the potential that all this data can be

used in a constructive and positive way if we really take full advantage of existing authority under statute.

We really join the call for health plans and insurers to comply with the law and demonstrate the impact of the Office of Health Care Affordability growth targets on rates. It is essential that they be required to do that, and that OHCA is given the information that they need to enforce that.

Of course, we gather here at a time when millions of Californians are losing health care coverage, and millions more may lose it, and at the same time suffering from the kind of cost increases that Ms. Capell identified. And that, of course, is a result from the federal cutbacks, but it falls on the state to respond. And we believe, as this chart shows, that the exorbitant profits and the reserves held as tangible net equity of California's largest health plans are a potential source of revenue that can address the access crisis and lower costs. It was not part of the data presented here, so we wanted to provide some, because it is quite extraordinary. I mean, these -- the tangible net asset -- tangible net equity held by these largest health plans are far in excess of the required minimums.

You could even increase those minimums and you would still find Kaiser Permanente, for example, at excess TNE of nearly $70 billion. That money is generated from the premiums paid by plan members. That's where that money comes from. What is it being used for at a time of escalating costs and crisis in access. We submit that it needs to be used to address that.

And at the same time, you look at other health plans. There you have got Blue Shield of California, 3.7 billion. Anthem Blue Cross, nearly 1.9 billion in excess TNE. You can just go down the list. It is quite extraordinary.

And we can, I think, fairly say that safety net providers, rural hospitals, are under severe financial threat. This pool of money created by Californians when they paid their health plan premiums should be used to address that crisis. It should be used to help solve the financial problems that safety net providers in particular and rural hospitals face. Thank you, Alma.

If you look at the rate increases that we have seen. And I just want to use Kaiser again, a premiums over time case study. If you look at the 15 years between 2010 and 2024, Kaiser on average has increased its individual plan premiums by 116%. In the past -- that same 15 year period 2010 to ’24, Kaiser on average has increased its small group plan premiums by 123%.

That compares -- that far outstrips the gain in household income. Where have those rate increases gone? Well, part of it has gone to creating that tangible net equity amount. This is an opportunity for the health plans to step up and say we will do our share. We will do our part. Because Californians have paid us this money and we will pay them back by ensuring that they have the access to care they need and not be subject to excessive rate increases.

These enormous financial reserves have been paid by businesses. They have been paid by workers who didn't get a wage increase because the money was going to health benefits. Small business owners can't afford it, so they don't provide coverage. If they do, they are subject to these premium increases. Of course, this affects -- these payments come from all segments of the market including those commercial plans in public programs.

What we have is a situation now where the reserves are spent according to the priorities of the companies and the health care executives. This is our opportunity to say no, to say no to the plans. No. You must actually use

those reserves created by Californians, in the interest of Californians, to ensure that we get the care we need.

Thank you for what you are doing. Thank you for this transparency. Thank you for the incredible data and information we got. Let's put it to use and make sure that Californians can afford the care they need. Thank you so much.

MS. LEVY: Thank you so much.

MS. YOUNG: (Adjusting microphone.) Whoops. I'll just hold it.

MS. LEVY: Yes, we might need to tighten it, sorry.

MS. YOUNG: Yes, thank you.

MS. LEVY: Everyone is a different height here.

MS. YOUNG: Thanks very much. Yeah, perfect. Thank you. Okay.

MS. LEVY: If you could please state your name and organization.

MS. YOUNG: My name is Cindy Young, and I serve as a Vice President for the California Alliance of Retired Americans, CARA. CARA represents over 1 million seniors and disabled Californians. As seniors, we see how the cost of health insurance is impacting our children and our grandchildren. So, I am going to share a story today about my family's experience, but I want you to know it is not unique to me. It is not unique to every single senior in California with what we are seeing our children and our grandchildren go through.

Kyle and Jessica are my niece and nephew. They are an average couple. They have two children in elementary school. They are self-employed and they pay $24,000 a year for insurance for their family. What is unconscionable is that they have a $1,000 deductible, huge copayments when

they access the system. So much so that I see them making sure that their two daughters get the care that they need, but when it comes to, I see a lump, I see something else happening in my body, they choose not to go because they can't afford the out-of-pocket costs. And I am telling you, this is not unique to my niece and nephew, it is what is happening to families in California.

So, now is the time to hold the insurers accountable for California to get what we deserve and what we need. Michael presented a chart here earlier, where billions of dollars are being put away in reserves, more than what the state requires. I see no reason why in this time that we are in a unique point in our political system. H.R. 1 took billions of dollars out of our health care system, and we have another source to be able to backfill that. I urge you to consider that. Using that money in a way that is going to help people that have already paid into that system, right? And to make sure that those that those health plans have the reserves that they need, they just have billions of dollars more than what is required by the state.

I want to thank you for your work, and I want to particularly thank OHCA for the work that it has done. It has been enlightening to see the information that they have uncovered, and I urge you to act expeditiously to help California's working families be able to survive this crisis. Thank you.

MS. LEVY: Thank you.

MR. MCLEAN: Thank you. Hi. My name is Bruce McLean. I am here on behalf of the Butte County Health Care Coalition. We are celebrating our 36th year of actively working to achieve universal health care. I live in Butte County, part of the rural north state, and I think that you probably have heard that the only hospital in the neighboring county, that is Glenn County, closed last

year. And it is, I think, just a harbinger of what is coming down the chute as a result of the big, ugly bill that has cut so much money from health care from the federal government. I know we have to cover some of those holes here, and I do agree with my colleagues who have suggested that using some of these huge funds that have been set aside that are way above what is necessary could be part of the solution for the governor's budget.

But long-term I am of the opinion that the Governor's Commission for Healthy California, that one of its conclusions was that we are going to suffer over the next 10 years approximately $500 billion in increased medical costs only from inflationary costs, not by adding any services or adding any additional people covered, unless we move to a unified financing system. We are already two and a half years into that so we haven't moved into the unified financing system so we have -- we have already incurred a good portion, a quarter of the expected $500 billion cost. So, this is something I would like you to keep in mind as you are doing your work, please. Thank you.

MS. LEVY: Thank you.

MR. UMEMOTO: (Adjusted microphone.) It doesn't have to be raised or lowered too much. Well, thank you so much. My name is Keith Umemoto. Thank you for providing this hearing for us in terms of, for purpose of public comment. My name is Keith Umemoto. I am with California Alliance for Retired Americans. Actually, I am also a retiree from the California state government, of which half my tenure was with the legislature and then I worked with Senator Al Alquist, Senator Martha Escutia and Senator Diane Watson. And the latter two with Senate Health and Human Services Committee and Senator Al Alquist with the Senate Budget and Fiscal Review Committee on subcommittee,

am I saying too much, Subcommittee number 3. So, Beth knows because we worked together a lot on that.

But anyway, for context purposes I think it is really important to hear the anecdotes and the impact it has. I will outline one anecdote that doesn't apply directly, but indirectly to what we are talking about today, in the sense that health care premiums dictate who gets health care.

So, when my brother was pre-Medicare eligible he was diagnosed with abdominal aortic aneurysm, and they said it was elective surgery. He got a second opinion and decided he was going to get it. This is right before COVID hit so thank goodness because if it was elective surgery he may not be with us today. He was insured by the ACA, and it was affordable at that time for him. And when I visited him in his hospital bed he said he knew somebody else that had the same diagnosis. He is no longer with us because he did not have health insurance because it was too costly. And that provides a real strong justification to really review the level reserve that is appropriate in terms of looking at the rates and reducing some of those rates, because the impact is the difference between my brother alive today and a friend of his that is not.

The other thing that I think is very important in your consideration is, as much as I don't like to say this, part of the H.R. 1 is the for-profit sector of the health care industry, even though we have seen the reserve up to 2024-25, their reserve, their profit margin is going to be substantially more because of the corporate tax code. So, if we are investing some of this reserve on people to save their lives, it is well worth it because prospectively, at least those in the for-profit sector of the health care industry are going to profit more and their net is going to be more. So, it is not as if you are using a reserve per se and it is going

to be per se capped out. We know the reserve is going to be even more when the rates go up. And as a result of that, a lot more individuals will not be protected with care.

And it kind of goes back to my initial anecdote. Do we want the rates to continue to go up and increase these individuals that cannot afford these rates to be in the decision of that other person, a friend of my brother's that doesn't have care, that can't have that six, seven or six -- over six figure operation so that he's alive today. So, that is my little anecdote. I really appreciate your consideration in really looking at reserves, they are higher than they are supposed to. You know the for-profit sector of the health care industry will have a substantial increase as we proceed, and as a result a lot of individuals will not be getting insurance and they are either going to die or they are going to go to the emergency room, which is going to be much more expensive. So, thank you so much.

MS. LEVY: Thank you. We have our last person in the room. If anyone else in-person would like to make a comment, please line up. Yes.

MR. LARA: Thank you very much. Thanks. Good afternoon. My name is Gilbert Lara here on behalf of Biocom California. We are the largest life sciences trade association. We represent biotechnology organizations, pharmaceutical, medical device, and diagnostic companies of all sizes. We also represent research institutions, universities and organizations.

We submitted formal public comment -- formal written comment to the DMHC via email, so I will keep my remarks brief today and appreciate the Department's work. We believe the 2024 report offers an incomplete view of the health care cost drivers today. I would like to highlight three points we observed

in the report.

First, the data shows that prescription drugs accounting for just 15.4% of premiums, yet health care plan profits surged by over 128% year after year.

Second, the report artificially inflates drug costs by inappropriately counting medical devices and testing supplies as prescription drugs.

Finally, the report notes $3.15 billion in manufacturer rebates, but entirely fails to track how PBM managers, or pharmacy benefit managers, retain these savings rather than lowering out of pocket costs for patients at the pharmacy counter.

We appreciate the work DMHC is doing to collect all of this data year after year, and we urge the Department to continue to adopt a framework, a reporting framework that accurately reflects the true costs, true cost drivers. Thank you.

MS. LEVY: Thank you.

MR. WEBER: Hi. My name is C.T. Weber. I am one of the Vice Presidents of California Alliance for Retired Americans, on the Board of Directors, and just want to make a couple points.

And that is that because of H.R. 1, millions of people in California are going to be losing some health care coverage. And that over the years we have been creating a lot of reserves because of the excess rates we have been paying, and we now think that these reserves should be scooted over to help people in need of health care. And so just wanted to supplement that information. Thank you.

MS. LEVY: Thank you. Okay, seeing no additional commenters in

the room we will move to our online folks who would like to give public comment. And the first one we have up is Michelle Johnston. We can unmute Michelle. Michelle, you can proceed.

MS. JOHNSTON: Good afternoon. Thank you. Thank you so much for holding this meeting. I am Michelle Johnston, Director of Advocacy and Policy with the National Multiple Sclerosis Society, and I am one of the over 68,000 Californians living with MS. MS is an unpredictable disease of the central nervous system. Currently there is no cure. Symptoms may vary from person to person and may include disabling fatigue, mobility challenges, cognitive changes and vision issues. To prevent further disease progression, it is essential that individuals begin an FDA-approved disease modifying therapy as soon as possible following their diagnosis and continued adherence to these medications are essential for treatment effectiveness. Delays or gaps in necessary diagnostic tests or treatments can worsen the prognosis for an individual living with MS and may lead to irreversible consequences and disease progression.

MS is an expensive disease. It may impact one's ability to work. It could generate steep out-of-pocket costs related to medical care, rehabilitation, home modifications, transportation and more. A study published in 2022 reported that the average cost of living with MS at that time was over $88,000 per year, with over $65,000 of those costs attributable to excess direct medical costs.

As of July of last year, the median annual cost of brand disease modifying therapies for MS was over $113,000. Time on the market does not guarantee a reduction in costs, as seven out of the nine DMTs that have been on the market for at least 12 years are priced over $100,000 a year and continue to see regular price increases. We supported the PBM licensing and SB 41 and we

look forward to its implementation.

I know people with MS who have skipped diagnostic tests due to not being able to afford a copay, someone who sold a vehicle to pay for her MRI, and another who has paid $3,000 out-of-pocket for a single round of their disease modifying therapy. Personally, even with insurance, I have paid up to $2,500 for a four-week supply of my DMT.

We appreciate the efforts of OHCA, DMHC and CDI to improve health care affordability. We thank you for your attention to this important and complicated issue. The Society will continue to look at the entire health care system and encourages these departments to continue your work to enable all Californians to receive health care that is accessible, affordable, equitable, high-quality and universal. Thank you.

MS. LEVY: Thank you. Next up online we have Lizzy Tapia. You can begin, please.

MS. TAPIA: Okay. Hi, everyone. My name is Lizzy Tapia. I am the President of Unite Here Local 2, which is the hotel and food service workers union in the Bay Area. We represent about 15,000 workers in hotels and food service.

In 2024 our members in hotels went on strike for 93 days, which was largely because of the cost of health care. Just to maintain our health care plans that we have because the costs continue to go up so drastically every year. And the costs are just out of control. It gets to the point where we can't even really blame the employers, you know, blame Hyatt, blame Marriott, blame Hilton, you know, for being frustrated, because they don't have control over the cost of health care and we don't either.

Being on strike is really tough. We run 24-hour picket lines seven days a week. You know, our members lose their voice on strike. They wonder every day if and when we will prevail. In 2024 our strike went all the way, you know, we started with initial strikes on Labor Day, and we went through Halloween, we went through Thanksgiving, and we settled on Christmas Eve of 2024. So, you can imagine how painful that is to really, to sacrifice your livelihood, to uproot your life for three months just to keep what you have on health care. You don't even see things improve; you just see them stay the same. So, this practice of fighting our employers, you know, to ultimately prevail, to win, only to take those economic gains and turn them over to health care companies is just absurd and it is not sustainable.

I want to say that our rates for Kaiser and Blue Shield have gone up 7%, 8%, 9%. They are not even trying to comply with the OHCA guidelines, and the state needs to do something about this. This is really an unsustainable thing for working people. It makes it so that people cannot survive. And this pattern of having to continually fight just to maintain what we have, this is not something that people should have to go through. It is time that the state regulates these health care companies more. Thanks.

MS. LEVY: Thank you. Before we get to our next public comment I just want to note we only have two more raised hands, and I believe everyone in the room who wished to give comment gave so already. So, if you are online and you want to give comment I would encourage you to raise your hand now so we can call on you before we conclude the meeting.

So, with that, next we have Michael Karsh.

MR. KARSH: Yeah. How can -- Blue Shield has raised my rate

from $619 a month, they kept that in both 2021 and 2022. But then 2023 they raised it to $701 a month, then for 2024 $819 a month, then for 2025 $900 a month. Now in 2026 it is $1,029 a month. How could they possibly be in compliance? It seems like they almost can't be, and can the state do anything to get them into compliance because I can't afford my health insurance anymore.

MS. LEVY: Thank you for your comment.

Next, we have Georgia Brewer.

MS. BREWER: Hello?

MS. LEVY: Yes.

MS. BREWER: Hi, thank you and good afternoon. I am Georgia Brewer, Associate Director of the California OneCare Education Fund and HEAL California. Thank you for your work to bring transparency to health care pricing.

Californians from every walk of life desperately need help with health care costs and we need that help now. Given the great need and consistent with remarks made earlier, I think we should take a look at health insurers' reserving practices. Why not hold them accountable for continuing to charge excessive premiums while sitting on billions of dollars in reserves? Kaiser Permanente alone is sitting on a reserve fund of over 2,000% of that required by law. So, given the huge excess profits insurers have gained at the expense of California families and businesses, they should have no trouble complying with the OHCA growth targets on premiums, deductibles and copays.

Moreover, while we keep working on winning true health care equity with a publicly funded universal health care system, let's dedicate insurers' excess reserves to making health care more affordable now, closing the funding shortfall and making up for the H.R. 1 subsidy cuts. Again, thank you.

MS. LEVY: Thank you for your comment.

And the last hand we have, Victoria Heric.

MS. HERIC: All right. Thank you so much for providing this opportunity to speak and also for all the data that you are collecting. It is great how there are organizations out there sending out emails to let us know how we could come here and see all this information without just complaining to our friends and family or just complaining on my Facebook wall, as I commonly do.

I have been on the ACA since the very beginning. I stay on an HMO plan in order to keep my care manageable. Last year I battled a Long-COVID bacterial infection, which I would describe the process as sheer hell, running the gauntlet of, you know, prior authorizations and what is going to be allowed and just fighting every single battle. And so to see some of your data about how, you know, the large group, they get all of those -- you know, they get more choice and it seems like they are getting more approvals, or they are getting the opportunity to actually spend the money they put in.

It is frustrating and it is scary year after year to see my premium go up; and then also the marketing materials that go with that that just justify it, say it is great, that it is this average. Like we wouldn't notice it or something when we are the ones who are paying out of our pocket and have to figure this out on our taxes year after year. And to hear that these health care companies have these reserves, it is just absolutely outrageous.

Like back when our rate was what it was at the beginning of your chart in 2017, yeah, it was way more manageable. Now it is like the only way that you can get away with affording one of these plans is to, you know, lie, cover your income, get fired, all these random things that it is just insane. So, those

reserves should go back to lowering our premiums. The governor hasn't done enough. I am glad that this was signed into law so we have this data. But we really do need to think about health care for all and making something that is affordable. Thank you.

MS. LEVY: Thank you for your comment.

That was the last raised hand. So, we will give it one more minute in case anyone has been multitasking or had to leave the Zoom and is coming back.

But with that time let me mention, let me first thank everyone who is here in person and who joined online. Thank you for sharing your ideas, your comments, your thoughts and especially your personal stories about accessing health care services. So, again, we appreciate and we took note of everyone who gave verbal public comment. If you are not -- I think some people had mentioned they will be sending in written comment. And if you are not somebody who wants to stand up, no problem. You can send in written comment until 5:00 p.m. on March 18, 2026, to publiccomments@dmhc.ca.gov.

So, with that we have concluded the public comment section and we will move to wrap up. Again, thank you all for your time and attention here today. All the presentations will be -- are on the DMHC website, and I believe there was a lot of information on the California Department of Insurance website.

Again, we want to thank our colleagues from CDI and from OHCA who have joined us to make this meeting more comprehensive. And again, thank you all for being here and we will conclude the meeting. Thank you all.

(The public meeting concluded at 3:02 p.m.)

--o0o--

CERTIFICATE OF REPORTER

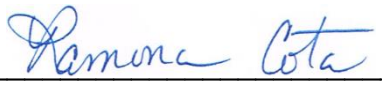
I, RAMONA COTA, an Electronic Reporter and Transcriber, do hereby certify:

That I am a disinterested person herein.

That the foregoing California Department of Managed Health Care Public Meeting on Health Care Premium Rates and Prescription Drug Cost Transparency was electronically reported by me and I thereafter transcribed the recording.

I further certify that I am not counsel or attorney for any of the parties to said Public Meeting, or in any way interested in the outcome of said matter.

IN WITNESS WHEREOF, I have hereunto set my hand this 22nd day of March, 2026.



RAMONA COTA, CERT**478

.